

MINIMALLY INVASIVE
ABDOMINAL SURGERY SPECIALISTS
A PART OF THE NICHOLSON CLINIC

PLEASE LIST YOUR FULL LEGAL NAME:

LAST: _____ FIRST: _____ MIDDLE: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PLEASE ENTER YOUR CONTACT INFORMATION:

1st Choice: Home Mobile Work () _____ - _____

2nd Choice: Home Mobile Work () _____ - _____

E-MAIL: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____ PHONE # _____

Emergency contact may receive information about my medical condition? (Please one) Yes No

SSN: _____ DOB: ____/____/____ AGE: _____ GENDER: F M

MARITAL STATUS (Optional): Married Divorced Widowed Single Other _____

Which best describes your ethnicity? Hispanic/Latino Origin Non-Hispanic/Non-Latino Origin

Which best describes your race? Asian Black American Indian/Alaska Native Native American/Pacific Islander White Other

EMPLOYER: _____ OCCUPATION: _____

PRIMARY CARE PHYSICIAN: _____ Phone: _____

REFERRING DOCTOR: _____ Phone: _____

Address: _____

My physician(s) may receive information from Abdominal Surgery Specialists regarding my surgery? (Please one) Yes No

PLEASE INCLUDE A FRONT & BACK COPY OF YOUR INSURANCE CARD

INSURANCE INFORMATION: (Please be very detailed – incomplete data may delay processing.)

INSURANCE CO.: _____ PLAN TYPE: HMO PPO POS

ADDRESS: _____ ID#: _____

GROUP #: _____ PHONE #: _____

NAME OF INSURED: _____ INSURED'S DOB: _____

RELATIONSHIP TO PT: _____ SS# (IF OTHER THAN PT): _____

EMPLOYER NAME: _____

SECONDARY INSURANCE CO.: _____ PLAN TYPE: HMO PPO POS

ADDRESS: _____ ID#: _____

GROUP #: _____ PHONE #: _____

GROUP #: _____ PHONE #: _____

NAME OF INSURED: _____ DOB: _____

RELATIONSHIP TO PT: _____ SS# (IF OTHER THAN PT): _____

EMPLOYER NAME: _____

PATIENT OR RESPONSIBLE PARTY

DATE

HEALTH AND MEDICAL HISTORY

(Fill out as completely as possible.)

HEIGHT: _____ CURRENT WEIGHT: _____

HAVE YOU EVER HAD *(Please check each that apply)*

- Gallbladder Surgery Year _____ Type _____
- Spleen Surgery Year _____ Type _____
- Esophagus Surgery Year _____ Type _____
- Stomach Surgery Year _____ Type _____
- Hernia Repair Surgery Year _____
- Caesarian Section Year _____
- Abdominal Hysterectomy Year _____
- Prior Weight Loss Surgery Year _____

HEALTH AND WELLNESS INFORMATION: *(For any "yes" answers list a diagnosing or treating physician.)*

<u>DESCRIPTION</u>	<u>YES</u>	<u>NO</u>	<u>YEAR</u>	<u>DIAGNOSING PHYSICIAN</u>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Snoring	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sleep Apnea Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
CPAP	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
BiPAP	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Indigestion/Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Gastroesophageal Reflux	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Degenerative Joint Disease/Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Lower Back	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Hips	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Knees	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Ankles	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Edema/Swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Legs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Ankles	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hypertension (High Blood Pressure)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Self	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Family History	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Self	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Family History	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High Cholesterol/Hyperlipidemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Urinary Incontinence (Leaking when you cough or sneeze)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
COPD/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Pulmonary Embolism	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chron's Disease/Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hepatitis B or Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

DO YOU HAVE A HEART CONDITION: YES NO If yes, please describe: _____

DO YOU HAVE ANY OTHER UNDERLYING MEDICAL CONDITIONS? YES NO, If yes, please describe: _____

IS YOUR FATHER LIVING? YES NO CAUSE OF DEATH: _____

IS YOUR MOTHER LIVING? YES NO CAUSE OF DEATH: _____

RECENT TESTING:

PHYSICAL	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DATE: _____
CHEST X-RAY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DATE: _____
UPPER GI	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DATE: _____
ECHOCARDIOGRAM	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DATE: _____
EKG	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DATE: _____

INDICATE ANY NEGATIVE RESULTS: _____

GENERAL AND LIFESTYLE INFORMATION:

DO YOU SMOKE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DO YOU USE ALCOHOL?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
HAVE YOU SMOKED?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	HOW OFTEN?	<input type="checkbox"/> DAILY	<input type="checkbox"/> WEEKLY
YEAR QUIT	_____			<input type="checkbox"/> OCCASIONALLY	<input type="checkbox"/> RARELY
HAVE YOU EVER HAD A PROBLEM WITH SUBSTANCE ABUSE?				<input type="checkbox"/> YES	<input type="checkbox"/> NO

PLEASE TAKE A MOMENT AND TELL US HOW YOU HEARD ABOUT OUR PROGRAM:

_____ INTERNET/ABDOMINAL SURGERY SPECIALISTS WEBSITE	_____ PCP/REFERRING DOCTOR
_____ INTERNET/NICHOLSON CLINIC WEBSITE	_____ INSURANCE COMPANY
_____ TV/RADIO/MAGAZINE ADVERTISEMENT	_____ FRIEND / FAMILY MEMBER
_____ CURRENT PATIENT, IF SO WHO? _____	

I REALIZE I AM RESPONSIBLE FOR CHARGES INCURRED FOR MY CARE SHOULD MY INSURER FAIL TO REIMBURSE IN AN ACCEPTABLE AND TIMELY MANNER.

PATIENT SIGNATURE

DATE OF BIRTH

DATE

We often make referrals to medical providers that may be out of network with your insurance plan because we believe them to be quality providers. As a standard of this office, we may refer to Baylor Regional Medical Center at Plano, Baylor Surgicare Garland, Crescent Medical Center, Medical City Frisco, Diez Services Anesthesia, ROON PLLC Anesthesia, Clinical Pathology Labs (CPL), and M3 Sleep Services of Texas, . The surgeons associated with this practice may or may not have a personal investment in these or other healthcare facilities. You are invited to discuss this with us or our office staff if you desire.

Nick Nicholson, M.D.

Thomas Roshek, M.D.

Brian Long, MD

Heartburn/ Reflux Questionnaire

Patient Name: _____ Date of Birth: _____

Instructions: please check the box to the right of each question using the scale below.

	Question	0	1	2	3	4	5
<p>Scale</p> <p>0 No symptoms</p> <p>1 Symptoms noticeable but not bothersome</p> <p>2 Symptoms noticeable and bothersome, infrequent</p> <p>3 Symptoms bothersome every day</p> <p>4 Symptoms affect daily activity</p> <p>5 Symptoms interfere with daily activities</p>	How bad is your heartburn?						
	Heartburn when lying down?						
	Heartburn when standing up?						
	Heartburn after meals?						
	Does heartburn change your diet?						
	Does heartburn wake you from sleep?						
	Do you have difficulty swallowing?						
	Do you have pain with swallowing?						
	If you take medication, does this affect your daily life?						
	How bad is the regurgitation?						
	Regurgitation when lying down?						
	Regurgitation when standing up?						
	Regurgitation after meals?						
	Does regurgitation change your diet?						
	Does regurgitation wake you from sleep?						

Instructions: Please answer the questions below by **circling** the appropriate response.

- How long have you been dealing with the symptoms above? 5 years 10 years 15+ years Other
- Have you tried medications to treat your symptoms in the past without relief? Yes No

Instructions: Please indicate which medications you have attempted in the past by **checking v** the duration of therapy.

Medication	5 yrs	10 yrs	15+ yrs	Other	Medication	5 yrs	10 yrs	15+ yrs	Other
Pepcid®					Aciphex®				
Famotidine					Rabeprazole				
Prilosec®					Prevacid®				
Omeprazole					Lansoprazole				
Dexilant®					Zegerid®				
Dexlansoprazole					Sodium Bicarb				
Protonix®					Tums®				
Pantoprazole					Rolaids®				
Zantac®					Pepto Bismol®				
Ranitidine					Other Medication				

Patient Signature: _____

Date: _____

FOR OFFICE USE ONLY

Reviewed by _____

Date _____

CURRENT PATIENT MEDICATIONS

DATE: _____

NAME: _____ DATE OF BIRTH: _____ MEDICATION ALLERGIES: _____

PHARMACY NAME: _____ PHARMACY PHONE: _____

Do you take antacids? (please check all that apply) **Date Started:** _____

Maalox Mylanta Tums Roloids Pepto-Bismol Pepcid (famotidine) Zantac (ranitidine) Tagamet (cimetidine) Prilosec (omeprazole)
 Aciphex (rabeprazole) RX Nexium (esomeprazole) RX Prevacid (lansoprazole) RX Protonix (pantoprazole)RX OTHER: _____

Vitamin/Mineral Supplements: (please check all that apply): Never Occasionally Daily

Multi Vitamin Vitamin D Vitamin B-12 (weekly) Other: _____

Do you have anemia? YES NO **IRON supplementation** YES NO

Date Started: _____ **How often?** _____

Do you take OTC pain relievers? (please check all that apply): YES NO **Date Started:** _____

Acetaminophen (Tylenol) Ibuprofen (Motrin, Advil) Naproxen (Aleve, Naprosyn) Aspirin OTHER: _____

Tobacco: Never Rarely Occasionally Frequently Quit (Month/Year): _____ **Alcohol:** Never Rarely Occasionally Frequently

CPAP/BIPAP: Never Occasionally Every Night

MEDICATION NAME/STRENGTH	ROUTE	DOSE	PURPOSE	DATE STARTED	DATE STOPPED
<i>EXAMPLE: SAMPLE 200mg</i>	<i>By mouth</i>	<i>1xday</i>	<i>Blood Pressure</i>	<i>May 2009</i>	
OTHER OTC MEDICATIONS:					

REVIEWED BY MEDICAL STAFF	
DATE/INITIALS	

DATE UPDATED: _____ PATIENT INITIALS: _____

DATE UPDATED: _____ PATIENT INITIALS: _____

DATE UPDATED: _____ PATIENT INITIALS: _____

DATE UPDATED: _____ PATIENT INITIALS: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY

YOUR PRIVATE HEALTH INFORMATION (PHI)

Each time you have contact with a healthcare provider, a record of your contact is prepared. This record may contain information such as signs, symptoms, results of examinations or tests, diagnoses, treatment, or future care plans. Your medical record is the physical property of Minimally Invasive Abdominal Surgery Specialists and Nicholson Clinic, but you have certain rights regarding the use and disclosure of your private health information (PHI). Abdominal Surgery Specialists and Nicholson Clinic however, have the right to use and disclose your PHI in the process of providing treatment, receiving payment and performing other regular healthcare operations such as:

- Documenting and describing the care you received for legal purposes
- Communicating with other healthcare providers involved in your care Educating healthcare professionals
- Medical Research
- Providing information for government and public health entities
- Evaluating and improving the care you receive and the outcomes achieved
- Billing and verification of services provided to you
- Conducting other routine healthcare operations

Protecting your privacy and maintaining the security of your PHI is an important responsibility of this practice. We are required by law to maintain privacy and confidentiality of your PHI, notify you of your rights in regards to your PHI, inform you of these privacy practices prior to gaining consent to treat, and notify you of changes/revisions to this Notice of Privacy Practices.

You may file a complaint with the Abdominal Surgery Specialists if you suspect any privacy rights violation. We will investigate the inquiry and inform you of the finding. In addition, you have the right to file a complaint with the Secretary of the Department of Health and Human Services.

EXAMPLES OF DISCLOSURE OF YOUR (PHI)

Healthcare delivery and treatment:

Your PHI may be provided to other healthcare professionals, such as other physicians, specialists, therapists, hospital based providers, and or other healthcare providers.

Billing and payment:

Your PHI is utilized to justify the level of care delivered to you and the charges incurred for the services. This information generally accompanies the bill and is sent to your payers and other third-party administrators.

Other healthcare operations:

You PHI may be disclosed to other businesses in order for my practice to perform its day-to-day operations. These may include business associates such as vendors, contractors used for credentialing and peer review, patient satisfaction surveys, utilization review, billing and claims management, medical research, disease control, quality improvement initiatives, management services organizations, laboratories, free standing diagnostic facilities, transcription services, and legal counsel. All business associates are required to appropriately protect the confidentiality of your PHI.

Treatment:

We may instruct a specialist to contact you to schedule an appointment or to provide you with information on treatment.

Other uses and disclosures:

We may utilize and disclose your PHI with others concerned with your health such as family members, relatives, caregivers, employers, and funeral directors. In addition, we may disclose your PHI through other communications and reports required to be made by healthcare professionals such as the public health department, law enforcement, the Food and Drug Administration, organ procurement organizations, corrections institutions, and workers compensation, where applicable.

Other disclosures of PHI not permitted or required by law will be made only with your written authorization You may revoke your authorization at any time provided that the revocation is in writing, except to the extent that Abdominal Surgery Specialists and Nicholson Clinic has already taken action in reliance on your prior authorization.

PATIENT CONSENT FORM REGARDING PHI

I understand that as part of my healthcare, Minimally Invasive Abdominal Surgery Specialists and Nicholson Clinic originates and maintains health records that may describe my health history, symptoms, examination and test results, diagnoses, treatment and/or plans for future care.

Notice of Privacy Practices of Abdominal Surgery Specialists provides specific information and description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review this prior to signing this consent.

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior consent, except as otherwise provided by law.

Listed below are individual(s) to whom I authorize use and/or disclosure of my PHI.

I request the following restrictions on the use and/or disclosure of my PHI.

By signing below and unless otherwise indicated, I request that information regarding my self-pay procedures not be disclosed to my health insurance company.

I have reviewed and understand the privacy practices of Abdominal Surgery Specialists as stated in *the Notice of Privacy Practices* dated April 1, 2003, and hereby consent to the uses and disclosures of my PHI so stated.

Signature of Patient or Legal Representative

Date of Birth

Print Name of Patient or Legal Representative

Date

I request that changes to the *Notice of Privacy Practices* be sent to me at the following address:

Email Informed Consent Form

Conditions for the Use of Email

It is the policy of Abdominal Surgery Specialists and Nicholson Clinic to make all email messages sent or received that concern the protected health information ("PHI"), a part of that patient's medical and financial records. Abdominal Surgery Specialists and Nicholson Clinic strive to protect and maintain patient PHI. However, there are numerous risks associated with email communication, which may include but not limited to misaddressed or undelivered emails, risk associated with use of employer owned email address, and/or delay in response time. Abdominal Surgery Specialists and Nicholson Clinic cannot fully guarantee the security and confidentiality of email communications. Thus, patients must consent to the use of email for confidential medical information after having been informed of the above risks. Consent to the use of email includes agreement with the following conditions:

- All emails to or from the patient concerning diagnosis and/or treatment will be made a part of the patient's records. As a part of medical record, other individuals, such as other physicians, nurses, other entities, such as other health care providers and insurers, may have access to email messages contained in medical records.
- Abdominal Surgery Specialists and Nicholson Clinic may forward email messages within the facility as necessary for diagnosis, treatment, and reimbursement. However, emails to entities unassociated with the patient's care, will not be forwarded, unless proper patient consent is received,
- Abdominal Surgery Specialists and Nicholson Clinic and its employees will make every effort to read and respond promptly to patient emails. **Because** Abdominal Surgery Specialists and Nicholson Clinic **cannot assure patients that recipients will read email messages promptly, patients must not use email in a medical or other emergency.**
- If a patient's email requires or invites a response, and the recipient does not respond within a reasonable time, the patient is responsible for following up to determine whether the intended recipient has received the email and when the recipient will respond.
- Because some medical information is so sensitive that unauthorized disclosure can be very damaging, **patients should not use email for communications concerning diagnosis or treatment of the following: AIDS/HIV infection; other sexually transmissible or communicable diseases; mental health or developmental disability; or alcohol and drug abuse.**
- Because employees do not have a right of privacy in their employer's email system, patients should not use their employer's email system to transmit or receive confidential medical information.
- Abdominal Surgery Specialists and Nicholson Clinic will take reasonable steps to protect the confidentiality of patient email, but is not liable for improper disclosure of confidential information not caused by Abdominal Surgery Specialists and Nicholson Clinic's gross negligence or wanton misconduct.
- If the patient consents to the use of email, the patient is responsible for informing Abdominal Surgery Specialists and Nicholson Clinic of any types of information that the patient does not want to be sent by email other than those set out above.
- Patient is responsible for protecting patient's password or other means of access to email sent or received from Abdominal Surgery Specialists and Nicholson Clinic to protect confidentiality. Abdominal Surgery Specialists and Nicholson Clinic is not liable for breaches of confidentiality caused by patient.

Any further use of email by the patient that discusses diagnosis or treatment by the patient constitutes informed consent to the foregoing. You may withdraw consent to the future use of email at any time by email or written communication to Abdominal Surgery Specialists and Nicholson Clinic, attention:

Stephanie G: HIPAA Compliance Officer
5500 Democracy Dr. #150
Plano, Tx 75024
Stephanie@Nicholsonclinic.com

I have read the above risk factors and conditions for the use of email, and I hereby consent to the use of email for communications to and from Abdominal Surgery Specialists and Nicholson Clinic regarding my medical treatment.

Signature of Patient

Email Address

Date

Printed Name of Patient

Date of Birth

Authorization Form to Appeal an Insurance Determination

To: _____

Member Name: _____ Date: _____

Member ID#: _____ Date of Birth: _____

I hereby authorize _____ to appeal my insurance carrier's determination concerning all denials of claims or incorrect payment of claims, on my behalf, as my designated representative. I understand that communication may contain:

All medical and financial information containing my insurance file, including but not limited to treatment for STD, alcoholism and drug abuse, abortion, mental health disorder and HIV status related to my examination, treatment, and hospital confinement in connection with the determination which is being appealed.

By signing below, I understand this information is privileged and confidential and will only be released as specified in this authorization or as permitted by law. This authorization is valid for a period of one year.

Signature of Member or Legal Guardian/Representative

Signature of witness or Designated Representative

Name and Title of Witness/Designated Representative (Printed)